STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/08/2012			ETED	
		ND REHAB CENTER	.	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0000	(PSR) to the Rec Licensure Surve This visit includ Revisit (PSR) to Complaint IN00 12/20/11.	r: 155572 100290390 RN-TC RN 12)	F00	000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

719512

Facility ID:

000471

TITLE

PRINTED: 03/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPLI 02/08/2	ETED
AUTUMN	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
			CROSS-REFERENCED TO THE APPR	DPE OPRIATE	

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DBIG	00	COMPL	ETED
		155572	A. BUIL			02/08/	′2012
			B. WIN		ADDRESS SYMV STATE SIN CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
A 1 17 18 48 1		UD DELLAD CENTED	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
AUTUMN	HILLS HEALTH AI	ND REHAB CENTER		DEMOT	1E, IN 46310		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157	•	nediately inform the					
SS=D	resident; consult w						
		nown, notify the resident's					
		ve or an interested family					
		re is an accident involving results in injury and has					
	the potential for re						
		nificant change in the					
		l, mental, or psychosocial					
		rioration in health, mental,					
	or psychosocial sta	atus in either life					
	threatening conditi						
		need to alter treatment					
		need to discontinue an					
	•	eatment due to adverse					
	•	to commence a new form decision to transfer or					
		dent from the facility as					
	specified in §483.1						
	-p	()-					
	The facility must a	Iso promptly notify the					
	resident and, if known	own, the resident's legal					
	•	nterested family member					
		ange in room or roommate					
		ecified in §483.15(e)(2); or					
	•	ent rights under Federal or					
	paragraph (b)(1)	ations as specified in					
	paragraph (b)(1) (JI 11113 36611011.					
	The facility must re	ecord and periodically					
		s and phone number of the					
		presentative or interested					
	family member.		l				
	Based on record	review and interview, the	F01:	57	F157 The facility is requestin	g	02/21/2012
	facility failed to	ensure residents'			paper compliance for this		
		notified and notified			deficiency. The filing of this p		
		ility to reinsert a urinary			of correction does not constitu	te	
	-	w blood sugar for 2 of 9			an admission that the alleged deficiency exists. This plan of		
					correction is provided as		
	residents reviewe				evidence of the facility's desire	e to	
	notification in a t	total sample of 9.			comply with the regulations an		
					Lp.,	0	

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Event ID: 719512 Facility ID: 000471

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155572	B. WIN			02/08/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	L			N 600 E COUNTY LINE RD		
AUTUMN	N HILLS HEALTH A	ND REHAB CENTER			ΓΤΕ, IN 46310		
(X4) ID	CLIMMADY C	TATEMENT OF DEFICIENCIES	-	ID	, I	(V5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
TAG		· · · · · · · · · · · · · · · · · · ·			continue to provide quality care		
(Residents #23 and #25)				The facility does notify the	G.		
					physician and family with a		
	Findings include	:			change of condition. 1)		
					Immediate actions taken for		
	1. Resident #23'	s record was reviewed on			those residents identified:		
	02/08/12 at 11 a.	m. The residents			Physician was notified of		
	diagnoses includ	ed, but were not limited			inability of being able to		
	-	urinary retention.			reinsert the catheter, the		
	to, dementia and	armary retention.			resident was sent to the		
	A A d	dan Minimum Data Cat			hospital when physician was		
		-day Minimum Data Set			notified of assessment and the	ne	
	` ′	ent, dated 12/16/11,			catheter was replaced. Physician has been notified	of	
		interview for mental			low blood sugars. Resident	OI	
	status should not	be conducted because			has had no adverse effects.	2)	
	the resident was	rarely/never understood			How the facility identified oth	, I	
	and the resident	had a short term memory			residents: 24 Hour Reports for	i i	
		oderately impaired			the past 30 Days have been		
	•	skills (decisions poor;			reviewed to identify any othe	r	
	_	required). The MDS			residents that have had a		
	•	ated the resident had an			change in condition and to		
					verify that the physicians we		
	indwelling urina	ry catheter.			notified of identified change.		
					Diabetic resident's blood sug		
		ladder " evaluation, dated			results have been reviewed f		
	12/23/11, indicat	ted the resident had a			the past 30 days to verify tha the physicians were notified		
	urinary catheter	for urinary retention.			results outside of parameters		
					3) Measures put into place/	<i>"</i>	
	A physicians ord	ler, dated 01/10/12, no			System changes: The Directo	or	
	time documented	l, indicated to change the			of Nursing or designee will		
		ry catheter, "tonight" and			review the 24 Hour Reports a	1	
	to obtain a urine	, ,			minimum of three times per		
		specimen for a			week to identify any changes	in	
	urinalysis.				condition and to verify that		
					physicians have been notifie	α	
	The resident's N	urses' Notes indicated:			of the change. Blood sugar		
					results will be reviewed by the Director of Nursing or design	i i	
	01/11/12 at 7:13	a.m., "attempted to			a minimum of three times pe	i i	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155572	B. WIN	IG		02/08/2012
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	ROVIDER OR SOLVEIE				N 600 E COUNTY LINE RD	
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER		DEMOT	ΓΤΕ, IN 46310	
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		heter unable to insert			week to verify that physician have been notified of any	S
		ify doctor." This was the			results outside of the ordere	d
		ion to indicate an attempt			parameters. Licensed Nurses	
	was made to cha	nge the resident's urinary			have been re-inserviced on	
	catheter.				timely notification of a reside	ent
					when there is a change in	
	01/11/12 at 1:14	p.m., "Needs extensive			condition or need to alter	
	assist of one staf	f for toiletingNo			treatment and Physician	
	complaints of pa	in or discomport (sic) at			Notification Policy. 4) How th corrective actions will be	le
	this time."	• • •			monitored: Director of Nursin	na
					or Designee will review the	.9
	01/11/12 at 10:3	4 p.m., "resident denied			results of audits and present	
		inating all shift stated 'im			the data and report any	
		fine,' writer gave resident			patterns or trends identified	to
		and asked him to urinate			the Quality Assurance	
	_	be sent to lab for analysis.			Committee monthly times the months and quarterly times	ree
		•			one. Nurses that are identific	-d
		t cup to nurse approx.			as being non-compliant will I	
	`	10 minutes later and			counseled. 5) Date of	
	I	ered the bottom of the			compliance: 2/21/12	
		esident denied difficulty			F323 The facility is	
	_	efused to allow nurse to			requesting paper compliance	
		omen@ (at) approx			for this deficiency. The filing this plan of correction does no	
	` * ′	and [sic] asked to			constitute an admission that th	
	* *	and resident consented.			alleged deficiency exists. This	
	abdomen was rig	gid with no give over the			plan of correction is provided a	
	bladder and resid	dent flinched and said			evidence of the facility's desire	
	'ouch.' he conse	nted to allow writer to			comply with the regulations an	
	attempt to reinse	rt catheter. writer was			continue to provide quality car The facility does thoroughly	e .
	•	ged MD and called the			investigate allegations of abus	e
	-	ee and received order to			and report to the Indiana State	
	_	name) ER to have it			Department of Health according	
	` •	his was more than 12			to the facility policy and state	
	`	nurse was unable to			reporting guidelines. 1)	
	reinsert the cathe				Immediate actions taken for those residents identified:	
	151115011 the cathe	2001 at 1.13 a.111.)			. เมองอะ เองเนอมเจ เนอมเมเซน.	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING COMPLETED			
		155572	B. WIN	G		02/08/2012	
NAME OF P	ROVIDER OR SUPPLIER	3	_		ADDRESS, CITY, STATE, ZIP CODE		
					N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER		DEMOT	ΓΤΕ, IN 46310		
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
					Resident was brought back		
	01/12/12 at 1:07	a.m., "resident being			inside the facility without injury. All door alarms were		
	seen at (hospital	name) for er [si])			checked to ensure that they		
	evaluation and tr	reatment at this			were properly functioning. A		
	timeresident co	ontinues to urinate small			Mag-lock was applied to the	`	
	amounts of urine	with abdomen hard and			door with an existing alarm.		
	distended with c				The resident was placed on t	he	
		sic] previously on			secured unit. 2) How the		
		MD aware of all above			facility identified other		
					residents: Elopement risk		
	entrys [sic] at thi	is time."			assessments were complete		
					for all residents in the facility		
	01/12/12 at 4:37	a.m., "resident returned			Those that were identified as		
	from (hospital na	ame)catheter			risk were already residing on the secured unit. 3) Measure		
	patentdenies ar	ny pain or			put into place/ System	63	
	discomfortabd	omen soft and			changes: Facility Staff were		
	non-distended'	•			re-inserviced on signs of		
					elopement risk and respondi	ng	
	There was a lack	of documentation to			to alarms. Elopement risk		
		sician had been notified			assessments will be complet		
					on admission to identify thos		
		hen the nurse was unable			exhibiting behaviors that ma		
		inary catheter from 7:10			them a risk for elopement. Al		
	a.m. through 9:3	0 p.m.			residents will be re-screened for elopement risk at least		
					quarterly and for a significan	, l	
		inary output record, dated			change in condition. Those		
	01/03/12 through	n 01/14/12, lacked			residents identified to be at		
	documentation tl	he resident had urine			risk, will have measures put		
	output on 01/11/	12.			into place to prevent an		
	-				elopement as defined by the		
	A. "Follow Un C	Question Report",			state reporting guidelines.		
	•	e RN Nursing Consultant			Residents who are observed	as	
		:10 p.m., indicated on			having new exit seeking behavior will be communicat	and I	
		p.m., 01/11/12 at 9:59			to the charge nurse/Social	. c u	
		•			Services for appropriate		
		12 at 2:22 a.m. (resident			placement/intervention to		
	still at hospital),	the resident was					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/08/2012	
	PROVIDER OR SUPPLIEF	ND REHAB CENTER	STREET A 10352 I	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	"CONTINENT [included use of catheter that doe During an interv p.m., the Director indicated the phynotified until 9:3	e. The form indicated, C-complete control indwelling urinary is not leak urine]" iew on 02/08/12 at 12:05 or of Nursing (DoN) visician had not been 0 p.m., about the urinary hable to be reinserted.		prevent elopement. An Elopement assessment would be completed at that time. Do alarms/mag-lock and wander-guard system is present to alert staff of a cognitively impaired resident attempting to elope Rounds will be made by team leaders three times per week for 3 months then monthly, during rounds alarms on doors will randomly set off and staff will be monitored for timely response. Management Staff have been in-serviced on Unusual Occurrence and Reporting Policy. 4) How the corrective actions will be monitored: Quality assurance rounds will be made as assigned by the Administrate daily to include random setting of alarms on various shifts a various doors to observe the timeliness of the response by the facility staff. Untimely response will be reported to the Administrator immediate for the appropriate action. To results of these audits will be reported monthly at the facility safety meeting for three months and then frequency we determined by the member of the quality improvement team. The Administrator is responsible for the coordination and monitoring 5) Date of compliance:	be ll f e or ng nd y ly he e e e e e e e e e e e e e e e e e e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 02/08 /	ETED	
	PROVIDER OR SUPPLIER	ND REHAB CENTER	P. W. A.	STREET A	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	2. Resident #25's 2/8/12 at 10:25 a diagnoses includ to, diabetes, emphypertension. Physician's order indicated blood scheck physicians (amount of insul sugar result). SI "0-59= 0 (no insul A January 2012 Administration I resident's blood was 54 and on 1/2 The resident's redocumentation to find the low blood. During an interview p.m., the RN Nu indicated there we indicate the residential of the low blood. During an interview indicated there we indicate the residential of the low.	serecord was reviewed on a.m. Resident #25's ed, but were not limited physema, and are, dated 12/17/11, sugar three times a day, sorders for sliding scale in given based on blood iding scale is as follows: ulin) call physician" MAR (Medication Record) indicated the sugar at 7 a.m. on 1/15/12 (20/12 was 45.) cord lacked the physician was notified sugars. iew on 02/08/12 at 2:20 resing Consultant was no documentation to lent's physician had been w blood sugars. iew on 02/08/12 at 3:10 dicated she had contacted			2/17/12		
		ysician and physician's were unable to recall if					

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	of Correction identification number: 155572	A. BUILDING	00	COMPLETED 02/08/2012
NAME OF I	PROVIDER OR SUPPLIER		ORESS, CITY, STATE, ZIP CODE	
AUTUM	HILLS HEALTH AND REHAB CENTER		E, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	they had been notified of the low blood sugars.			
	A facility revised policy, dated 01/12, received from the DoN as current, and titled, "PHYSICIAN/FAMILY/RESPONSIBLE PARTY NOTIFICATION FOR CHANGE IN CONDITION" indicated, "To ensure that medical care problems are communicated to the attending physician in a timely, efficient, and effective manner1. Physician Notification is to include, but is not limited to:Change in condition that may warrant a change in current treatmentBlood glucose reading below 602. Physician Notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained." This deficiency was cited on 12/20/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-5(a)(2) 3.1-5(a)(3)			

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CC A. BUILDING B. WING	00	сом 02/0	e survey pleted 8/2012	
AUTUMN	ROVIDER OR SUPPLIER HILLS HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	X3) DATE SURVEY COMPLETED 02/08/2012	
	PROVIDER OR SUPPLIE	ND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	have been found neglecting, or mis court of law; or ha into the State nurs abuse, neglect, m misappropriation any knowledge it law against an enindicate unfitness or other facility staregistry or licensing. The facility must eviolations involving abuse, including it and misappropriate reported immediathe facility and to accordance with established procestate survey and. The facility must be alleged violations investigated, and potential abuse we progress. The results of all reported to the acceptance officials in accord (including to the sagency) within 5 and if the alleged appropriate corresponding to observe the sagendon observerse.	attreating residents by a lave had a finding entered se aide registry concerning distreatment of residents or of their property; and report has of actions by a court of aployee, which would for service as a nurse aide aff to the State nurse aide and authorities. The sensure that all alleged go mistreatment, neglect, or an injuries of unknown source tion of resident property are tely to the administrator of other officials in State law through dures (including to the certification agency). The ave evidence that all are thoroughly must prevent further hile the investigation is in an investigations must be	F0225	F225 The facility is requesting paper compliance for this	
	investigate and i	report to the Indiana State Health, an unusual		deficiency. The filing of this post correction does not constitute an admission that the alleged	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING COMPLETED		
		155572	B. WIN			02/08/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R			N 600 E COUNTY LINE RD	
A 1 1 T 1 1 A A		ND DELIAD CENTED				
AUTUMN HILLS HEALTH AND REHAB CENTER			DEMOT	TE, IN 46310		
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)		DATE
	occurrence relate	ed to a resident exiting			deficiency exists. This plan of	
	the building una	ttended for 1 of 3			correction is provided as	
		ere at risk for elopement			evidence of the facility's desire	
	in a sample of 9.	•			comply with the regulations an	
	in a sample of 7.	(Resident #1)			continue to provide quality car The facility does thoroughly	е.
	Eindings include				investigate allegations of abus	e
	Findings include	.			and report to the Indiana State	
					Department of Health according	
		cord was reviewed on			to the facility policy and state	
	2/7/12 at 2:30 p.	m. Resident #7's			reporting guidelines. 1)	
	diagnoses includ	led, but were not limited			Immediate actions taken for	
	to, dementia with	h behavioral disturbances,			those residents identified:	
	anxiety, and Alzheimer's disease.				Resident was brought back	
	unixiety, und 1112	nemer's disease.			inside the facility without	
	D : :: 1 : : : 1/7 : : : :	1			injury. All door alarms were	
		observed, on 2/7/12 at			checked to ensure that they	
		e locked Alzheimer's Unit			were properly functioning. A	L
	sitting in a chair	attending an activity.			mag-lock was applied to the	
	She had a sensor	alarm and wanderguard			door with an existing alarm.	h.a
	on.				The resident was placed on t secured unit. 2) How the	ne
					facility identified other	
	A quarterly MDS	S (Minimum Data Set),			residents: Elopement risk	
		indicated the resident had			assessments were completed	d
					for all residents in the facility	
		erm memory loss and was			Those that were identified as	
	severely impaire	d for daily decision			risk are already residing on t	he
	making.				secured unit. 3) Measures pu	t
					into place/ System changes:	
	An Elopement R	tisk Assessment, dated			Facility Staff were re-inservio	ed
	_	ted the resident had the			on signs of elopement risk a	nd
	ability to move a				responding to alarms.	
	_	diagnosis of Alzheimer's			Elopement risk assessments	
					will be completed on	
	, ,	lgement/impaired safety			admission to identify those	
		history of wandering. It			exhibiting behaviors that ma	
	indicated the res	ident "has a Wanderguard			them a risk for elopement. Al	
	bracelet in place	."			residents will be re-screened	
					for elopement risk at least	
	l		I		quarterly and for a significan	·

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155572	B. WIN	IG		02/08/2	2012
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	C.		10352 N	N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER		DEMOT	TE, IN 46310		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	A Social Service	note, dated 1/12/12 at			change in condition. Those		
		cated "Resident was			residents identified to be at		
	moved to the ACU (locked Alzheimer's				risk, will have measures put		
		· ·			into place to prevent an		
	, -	due to her exiting out of			elopement as defined by the		
		was easily redirected back			state reporting guidelines.		
	· ·	Family ws [sic] in			Residents who are observed	as	
	agreement with	move" The resident's			having new exit seeking		
	record lacked an	y other documentation			behavior will be communicat to the charge nurse/Social	ea	
	regarding the res	ident exiting the			Services for appropriate		
	building.	•			placement/intervention to		
	<i>S S</i> .				prevent elopement. An		
	Δn Internal Inve	stigation form, dated			Elopement assessment woul	d	
	1/11/12 at 11:35				be completed at that time. Do	oor	
					alarms/mag-lock and		
	•	Occurrence: The resident			wander-guard system is		
	· '	y through the double set			present to alert staff of a		
		Assisted Living unit by			cognitively impaired residen	t	
	the pool room. S	She was returned to the			attempting to elope Rounds		
	facility without i	njuryRelative to this			will be made by team leaders	•	
	occurrence the fo	ollowing statement was			three times per week for 3 months then monthly, during		
	provided: She (LPN #1) stated that she			rounds alarms on doors will		
	`	rolling down the incline			randomly set off and staff wi		
		ing lot. She (LPN #1)			be monitored for timely		
	_	as on the North Hall			response. Management Staf	f	
		exit door. She (LPN #1)			have been in-serviced on		
		· · · · · ·			Unusual Occurrence and		
		y promptly and assessed			Reporting Policy. 4) How the		
		njuries and assisted her			corrective actions will be		
	back into the fac	ility. She (LPN #1)			monitored: Quality assuranc	e	
	stated that the re	sident did not have any			rounds will be made as		
	injuries."				assigned by the Administrate daily to include random setti		
					of alarms on various shifts a	_	
	An Occurrence !	Management Log for			various doors to observe the		
		eked the elopement on			timeliness of the response by		
	1/11/12.	and the disperiment on			the facility staff. Untimely	'	
	1/11/14.				response will be reported to		
					•		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/08/2012
	PROVIDER OR SUPPLIEI	ND REHAB CENTER	STREET 10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD OTTE, IN 46310	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	(Director of Nur p.m., she indicate facility on 1/11/reported. She in Administrator w occurrences and reportable log. During an interve 2/7/12 at 4:30 p. Resident #7's "w She indicated she LPN #1 indicate opening and saw and she went to indicated Reside door on the Assi (the nurse) was of the nurse) was of the hall (hall going to the Wessaw Resident #7 her wheelchair a parking lot." She hear the alarm g she went out and brought her back			the Administrator immediate for the appropriate action. Tresults of these audits will be reported monthly at the facilisafety meeting for three months and then quarterly for a total of 6 months. The Administrator is responsible for the coordination and monitoring. 5) Date of compliance: 2/21/12	he e ity or

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/08/2012	
MUTUA	PROVIDER OR SUPPLIEIN HILLS HEALTH A	ND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	1/11/12, indicate Residents were in Residents were in Residential Resisound. The House indicated she was and saw Resider sidewalk from the building. The Irrelated interview members to indicated interview members to indicate alarm and why in During an interview members to indicate alarm and why in During an interview members to indicate alarm and why in During an interview members to indicate alarm and why in During an interview members to indicate alarm and why in During an interview members to indicate at 8:50 a. The policy was revisionally indicated the policy was revisional Consumption of the state regulating and 1/2012 and received because and 1/2012 and received by the policy of the poli	d Reporting," dated ived as current from the at 9:25 a.m., indicated asure that reportable recorded and monitored pliance with the state and			

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	of Correction identification number: 155572	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 02/08/2012
	PROVIDER OR SUPPLIER I HILLS HEALTH AND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	servicesPolicy Interpretation and Implementation: Occurrences to be reported: Facilities are required by law to report unusual occurrences within 24 hours of occurrence7. Resident Elopement A. A cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown" 3.1-28(d)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		ONSTRUCTION 00	(X3) DATE COMPL	ETED	
		155572	B. WIN	G		02/08/	2012
	PROVIDER OR SUPPLIER	ND REHAB CENTER		10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\TE	(X5) COMPLETION DATE
F0226 SS=D	The facility must d written policies and mistreatment, negresidents and mistreatment. Based on record facility failed to policy for investithe Indiana State (ISDH), an unus an elopement for for elopement in (Resident #7) Findings include Resident #7's rec 2/7/12 at 2:30 p.1 diagnoses include to, dementia with anxiety, and Alzland A quarterly MDS dated 10/25/11, i short and long te severely impaired making. An Elopement R 11/14/11, indicate ability to move a independently, a disease, poor judiawareness, and a	evelop and implement d procedures that prohibit lect, and abuse of appropriation of resident review and interview, the follow the facility's gating and reporting to Department of Health ual occurrence related to 1 of 3 residents at risk a sample of 9 residents. cord was reviewed on m. Resident #7's ed, but were not limited a behavioral disturbances, neimer's disease. d (Minimum Data Set), indicated the resident had rm memory loss and was d for daily decision isk Assessment, dated ed the resident had the	F02		F226 The facility is requesting paper compliance for this deficiency. The filing of this profession of correction does not constitution an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire comply with the regulations are continue to provide quality can the facility does thoroughly investigate allegations of abust and report to the Indiana State Department of Health according to the facility policy and state reporting guidelines. 1) Immediate actions taken for those residents identified: Resident was brought back inside the facility, no injury of emotional distress were noted. All door alarms were checked to ensure that they were properly functioning. Mag-low was added to the door in the Assisted Living in addition to the existing alarm. Key pade added to doors that were no equipped with wander-guard system. Resident was transferred to the secured Alzheimer's Unit. 2) How the facility identified other residents: Elopement risk assessments were complete for all residents in the facility.	polan ute f e to ond to ore. se e ong or ed. o s t l	02/21/2012

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	(X2) MU A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE COMPL 02/08/	ETED
	PROVIDER OR SUPPLIEIN	ND REHAB CENTER	•	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Ξ.	(X5) COMPLETION DATE
IAU	bracelet in place A Social Service 12:49 p.m., indice moved to the AG Unit) yesterday door. Resident with into the facility, agreement with record lacked an regarding the residual ding." An Internal Inventional Invention of the facility of doors on the AG the pool room. So facility without so cocurrence the fi provided: She (saw Resident #7 of the inner park stated that she we looking out the devited the facility the resident for it back into the facility stated that the resident for it back into the facility agreement with record lacked an regarding the resident of the pool room. So facility without so cocurrence the fi provided: She (saw Resident #7 of the inner park stated that she we looking out the devited the facility the resident for it back into the facility the resident for i	e note, dated 1/12/12 at cated "Resident was CU (locked Alzheimer's due to her exiting out of was easily redirected back Family ws (sic) in move" The resident's sy other documentation sident exiting the estigation form, dated a.m., indicated Occurrence: The resident y through the double set Assisted Living unit by She was returned to the injuryRelative to this following statement was LPN #1) stated that she rolling down the incline sing lot. She (LPN #1) was on the North Hall exit door. She (LPN #1) y promptly and assessed injuries and assisted her cility. She (LPN #1) sident did not have any		140	Those that were identified a risk have had wander guard bracelets applied or are alrowed to a secured un 24 Hour Reports for the past days have been reviewed to identify any unusual occurrences. None were identified. 3) Measures put place/ System changes: Documentation will be reviewed during morning meetings a minimum of three times per week to identify a exit seeking behaviors. The identified will have a new elopement risk assessments will be dequarterly and with significate changes. Twenty four hour reports will be reviewed by Director of Nursing or designee during morning meetings to identify any unusual occurrences. Administrator or designee ensure that a thorough investigation will be conduted for any unusual occurrence to ensure that a complete and thorough investigation has been completed and that appropentities have been notified. Rounds will be made by tealeaders three times per weel in the proper weel and thorough investigation has been completed and that appropentities have been notified.	eady it. st 30 o into ee any ose t rd one ont r the will cted es r ure gh riate	DATE
	January 2012 lac	eked the elopement on				-	

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	OF CORRECTION OF CORRECTION 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/08/2012
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352 N	DDRESS, CITY, STATE, ZIP CODE 1 600 E COUNTY LINE RD TE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with the DoN (Director of Nursing), on 2/7/12 at 4:10 p.m., she indicated Resident #7 exited the facility on 1/11/12 and it was not reported. She indicated the previous Administrator was tracking all unusual occurrences and it was not on the reportable log. During an interview with the DoN, on 2/7/12 at 4:30 p.m., she indicated Resident #7's "whereabouts were known." She indicated she talked with LPN #1 and LPN #1 indicated she saw the door opening and saw Resident #7 come out and she went to get her. LPN #1 indicated Resident #7 went out of the door on Assisted Living hall and she (the nurse) was on the North Hall. During an interview with LPN #1, on 2/8/12 at 9:20 a.m., she indicated she was on the hall (hall by the main dining room) going to the West hall. She indicated she saw Resident #7 come down the incline in her wheelchair and was "rolling across the parking lot." She indicated she did not hear the alarm going off. She indicated she went out and got the resident and brought her back in. "I reported it to her nurse, I was not her nurse that day." She indicated Resident #7 did have a		for 3 months then monthly, during rounds alarms on doc will be randomly set off and staff will be monitored for timely response. All staff has been in-serviced on observing for behaviors that might put residents at risk for elopeme such as exit seeking. Also, staff will report immediately any of those behaviors to the DON/Administrator. Management Staff have been in-serviced on Unusual Occurrence and Reporting Policy. 4) How the corrective actions will be monitored: Administrator or designee wireport any patterns or trends identified to the Quality Assurance Committee month times three months and quarterly times one. Administrator or designee wireport the results of audits of unusual occurrences and any patterns or trends that have been identified to the Quality Assurance Committee month for three months then quarte time's one. 5) Date of compliance: 2/21/12	s ag ant

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	of Correction identification number: 155572	A. BUILDING B. WING	COMPLETED 02/08/2012
	PROVIDER OR SUPPLIER I HILLS HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, S 10352 N 600 E COUN DEMOTTE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECT CROSS-REFEREN	S PLAN OF CORRECTION ITVE ACTION SHOULD BE ICED TO THE APPROPRIATE EFFICIENCY) (X5) COMPLETION DATE
	wanderguard on. Review of the Internal Investigation of 1/11/12, indicated three Residential Residents were interviewed and 2 of the 3 Residential Residents heard a door alarm sound. The Housekeeping Supervisor indicated she was returning from break and saw Resident #7 rolling down the sidewalk from the apartment side of the building. The investigation lacked interviews from other staff members to indicate if they heard the alarm and why it was not responded to. During an interview on 2/08/12 at 3:10 p.m., the Regional Consultant indicated per interview with the Administrator at the time of the occurrence, the staff did not hear the alarm, they were in the dining room and the nurse was working the other side of the building. She indicated the staff did respond because they went out and got her. During an interview with the DoN, on 2/8/12 at 8:50 a.m., she indicated the policy was revised in January 2012. She indicated the policy was copied right from the state regulations. She indicated the Regional Consultant said it was not reported because of the policy change. A facility policy titled "Administratiave		

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
		155572	A. BUILDIN B. WING	G		02/08/	2012
	PROVIDER OR SUPPLIE	ND REHAB CENTER	10	0352 N	DDRESS, CITY, STATE, ZIP CODE I 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	1/2012 and receip DoN, on 2/8/12 "Purpose: To ender occurrences are to facilitate comfederal laws. Por Occurrences reported: Policy Implementation: reported: Facilitate report unusual of the policy Implementation: report unusual of the policy Implementation in the policy Implement	d Reporting," dated ived as current from the at 9:25 a.m., indicated asure that reportable recorded and monitored pliance with the state and					

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	OF CORRECTION IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/08/2012
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to monitor for urinary output and assess a resident's abdomen/bladder after they were unable to reinsert a urinary catheter in a resident with a diagnosis of urinary retention for 1 of 9 residents reviewed for necessary care and services in a total sample of 9. (Resident #23) Findings include: Resident #23's record was reviewed on 02/08/12 at 11 a.m. The residents diagnoses included, but were not limited to, dementia and urinary retention. An Admission/5-day Minimum Data Set (MDS) assessment, dated 12/16/11, indicated a brief interview for mental status should not be conducted because the resident was rarely/never understood and the resident had a short term memory problem with moderately impaired decision making skills (decisions poor; cues/supervision required). The MDS assessment indicated the resident had an indwelling urinary catheter.	F0309	F309 The facility is requesting paper compliance for this deficiency. The filing of this portion of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desiruc comply with the regulations are continue to provide quality can the facility does provide servito attain and maintain the high level of functioning. 1) Immediate actions taken for those residents identified: Physician was notified of inability of being able to reinsert the catheter, was set to the hospital when physicians was notified of assessment and the catheter was replaced the hospital and the resident returned to the facility. 2) How the facility identified other residents: 24 Hour Reports of the past 30 Days have been reviewed to identify any other residents that have had a change in condition and to verify that the physicians we notified of identified change. Measures put into place/System changes: 24 Hour	plan ite e to nd to re. ices nest nt an ed. at : bw or er

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	A. BUILDII B. WING	NG	NSTRUCTION 00	(X3) DATE S COMPL 02/08/	ETED
	PROVIDER OR SUPPLIEI	R ND REHAB CENTER	1	0352 N	DDRESS, CITY, STATE, ZIP CODE I 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	12/23/11, indical urinary catheter A physician's ortime documented indwelling urinal to obtain a urine urinalysis. The resident's N 01/11/12 at 7:13 change foley catheter will not first documentat was made to character to catheter. 01/11/12 at 1:14 assist of one staff complaints of pathis time." 01/11/12 at 10:3 any problems ur [sic] peeing just a collection cup in it so it could be can [sic] brough (approximately) urine barely cov	ladder" evaluation, dated ted the resident had a for urinary retention. der, dated 01/10/12, no d, indicated to change the ry catheter, "tonight" and specimen for a urses' Notes indicated: a.m., "attempted to heter unable to insert ify doctor". This was the ion to indicate an attempt ange the resident's urinary p.m., "Needs extensive if for toiletingNo in or discomport [sic] at 4 p.m., "resident denied inating all shift stated 'im fine' writer gave resident and asked him to urinate be sent to lab for analysis. It cup to nurse approx. 10 minutes later and ered the bottom of the esident denied difficulty			Reports will be reviewed by the Director of Nursing or design a minimum of three times per week to identify any changes condition and to verify that physicians have been notified of the change. Licensed Nurses have been in-serviced on Physician Notification Protocol, Urine Output and abdomen/bladder assessment for residents with urinary retention. 4) How the correct actions will be monitored: Director of Nursing or Designee will review the results of audits and present the data and report any patterns or trends identified the Quality Assurance Committee monthly times the months and quarterly times one. Nurses that are identified as being non-compliant will be counseled. 5) Date of compliance: 2/21/12	nee r s in d d ive to	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		LDING	NSTRUCTION 00	(X3) DATE COMPL 02/08/	ETED
	PROVIDER OR SUPPLIER	ND REHAB CENTER	B. WIN	STREET A	NDDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	examine his abdo 2130 (9:30 p.m.) palpate abdomen abdomen was rig bladder and residouch. he consent attempt to reinse unsuccessful. paganswering services send to (hospital reinserted" (Thours since the noreinsert the cather of 1/12/12 at 1:07 seen at (hospital evaluation and treinserted with compain/dicomfort [safternoon shift] entrys [sic] at this hours after the father urinary cather of 1/12/12 at 4:37 from (hospital napatentdenies ar discomfortabdo non-distended"	a.m., "resident being name) for er [sic] eatment at this ontinues to urinate small with abdomen hard and to (complaints) sic] previously on MD aware of all above stime." (This was 18 cility could not reinsert ter) a.m., "resident returned ame)catheter by pain or comen soft and					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	LDING	NSTRUCTION 00	(X3) DATE COMPL 02/08/	ETED
NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER		10352 N	DDRESS, CITY, STATE, ZIP CODE I 600 E COUNTY LINE RD TE, IN 46310			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	by the facility w	sician had been notified hen the nurse was unable inary catheter from 7:10 0 p.m.				
	resident had bee	n assessed for urinary ition of the abdomen from th 9:30 p.m.				
	01/03/12 throug	rinary output record, dated h 01/14/12, lacked he resident had urine /12.				
	p.m., the RN Nu indicated if the r catheter, urinary been recorded as	riew on 02/08/12 at 3:10 arsing Consultant resident did not have a output would not have and the staff would have the resident was continent				
	received from the on 02/08/12 at 3 01/11/12 at 1:59 p.m., and 01/12/still at hospital), continent of urir "CONTINEN [included use of catheter that does	Question Report," le RN Nursing Consultant :10 p.m., indicated on p.m., 01/11/12 at 9:59 12 at 2:22 a.m. (resident the resident was le. The form indicated, T-complete control indwelling urinary es not leak urine]" The umentation of the amount				

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED
		155572	B. WING		02/08/2012
NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER		10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	p.m., the Director indicated the physical notified until 9:3 catheter being upon She indicated the in the Nurses' Noresident had voice had attempted to catheter until 9:3 indicated she wood documentation of the facility failed.	iew on 02/08/12 at 12:05 or of Nursing (DoN) ysician had not been 30 p.m., about the urinary hable to be reinserted. ere was no documentation otes to indicate the ded. She indicated no one or reinsert the urinary 30 that evening. She hould, "expect" to see of monitoring the resident. Was cited on 12/20/11. And to implement a correction to prevent			

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PRINTED: 03/05/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN NAME OF F AUTUMN (X4) ID PREFIX TAG	OF CORRECTION IDENTIFICATION NUMBER: 155572 PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETED 02/08/2012 (X5) COMPLETION DATE
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F0323	F323 The facility is requesting paper compliance for this deficiency. The filing of this of correction does not constitution an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire comply with the regulations at continue to provide quality can a continue to provide quality can a continue to provide quality can and report to the Indiana State Department of Health according to the facility policy and state reporting guidelines. 1) Immediate actions taken for those residents identified: Resident was brought back inside the facility without injury. All door alarms were checked to ensure that they were properly functioning. Mag-lock was applied to the door with an existing alarm. The resident was placed on secured unit. 2) How the facility identified other residents: Elopement risk assessments were complete for all residents in the facility Those that were identified a risk were already residing of the secured unit. 3) Measur put into place/ System changes: Facility Staff were	plan ute f e to nd to re. se e ng the

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	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 8/2012
	ROVIDER OR SUPPLIE	R ND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP N 600 E COUNTY LINI TTE, IN 46310		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				re-inserviced on signelopement risk and representation to alarms. Elopement assessments will be on admission to ider exhibiting behaviors them a risk for elopement risk and quarterly and for a schange in condition. residents identified the risk, will have measured into place to prevent elopement as define state reporting guide Residents who are on having new exit seeds behavior will be completed at that alarms/mag-lock and wander-guard system present to alert staff cognitively impaired attempting to elope I will be made by team three times per week months then monthly rounds alarms on do randomly set off and be monitored for time response. Management have been in-serviced Unusual Occurrence Reporting Policy. 4)	responding at risk completed attify those at that make ement. All screened at least ignificant Those at be at ures put an an abserved as ating amunicated Social riste ion to An ent would attime. Door attime. Door attime. Door attime. Those at resident Rounds at resident Rounds at leaders at for 3 y, during pors will be at staff will all all and	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/08/2012	
	NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	facility failed to adequate supervexiting the build residents review in a sample of 9 Findings include Resident #7's rec2/7/12 at 2:30 p. diagnoses include to, dementia with anxiety, and Alz			corrective actions will be monitored: Quality assurant rounds will be made as assigned by the Administration daily to include random sett of alarms on various shifts a various doors to observe the timeliness of the response of the facility staff. Untimely response will be reported to the Administrator immediate for the appropriate action. The results of these audits will be reported monthly at the facility staff and the facility are responsed for a total of months. The Administrator responsible for the coordination and monitoring to the properties of the coordination and monitoring to the properties of the coordination and monitoring to the coordination and monitoring the coordinat	tor cing and e by file lity c, file is	

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	OF CORRECTION OF CORRECTION 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/08/2012		
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	assessment, dated 10/25/11, indicated the resident had short and long term memory loss and was severely impaired for daily decision making.					
	An Elopement Risk Assessment, dated 11/14/11, indicated the resident had the ability to move about the facility independently, a diagnosis of Alzheimer's disease, poor judgement/impaired safety awareness, and a history of wandering. It indicated the resident "has a Wanderguard bracelet in place." A care plan, "Resident exhibits wandering with the potential for exit seeking behaviors," dated 4/10/11 and revised 11/7/11, indicated wanderguard in place. A Social Service note, dated 1/12/12 at 12:49 p.m., indicated "Resident was					
	moved to the ACU (locked Alzheimer's Unit) yesterday due to her exiting out of door. Resident was easily redirected back into the facility. Family ws [sic] in agreement with move" The resident's record lacked any other documentation regarding the resident exiting the building. An Internal Investigation form, dated 1/11/12 at 11:35 a.m., indicated "Description of Occurrence: The resident exited the facility through the double set					

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPL 02/08	ETED
NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER				STREET A	DDRESS, CITY, STATE, ZIP CODE I 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	the pool room. Se facility without is occurrence the form provided: (LPN) (Resident #7) roll the inner parking stated that she will looking out the exited the facility the resident for in back into the fact stated that the resident for in back into the fact stated that the resident #7's "will she indicated she LPN #1 indicated opening and saw and she went to go indicated Resided door on the Assist (the nurse) was controlled the parking lot." She indicated that the resident #7's "will she indicated she indicated Resided door on the Assist (the nurse) was controlled to the Wessaw Resident #7's the wheelchair at parking lot." She indicated in the wheelchair at parking lot."	hereabouts were known." e talked with LPN #1 and d she saw the door Resident #7 come out					

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	OF CORRECTION OF CORRECTION 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/08/2012		
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	she went out and got the resident and brought her back in. "I reported it to her nurse, I was not her nurse that day." She indicated Resident #7 did have a wanderguard on.					
	During an observation on 2/8/12 at 9:35 with LPN #1, she indicated the door she saw the resident through was the glass door past the Maintenance Office on the right. She indicated the Assisted Living door was not visible from where she was. She indicated she did not see Resident #7 come out the door.					
	During an observation, on 2/8/12 at 9:45 a.m., a key pad lock was noted by the door at the end of the Assisted Living door.					
	During an interview with the DoN, on 2/8/12 at 9:50 a.m., she indicated the Assisted Living door had an alarm at the time of the elopement. She indicated the alarm would go off if anybody went out the door. She indicated Resident #7 never tried to get out of the doors before. She indicated the resident's family was notified and were in agreement to move the resident to the ACU.					
	Review of the Internal Investigation of 1/11/12 indicated three Residential Residents were interviewed and 2 of the 3					

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Residential Residents heard the door alarm sound. The Housekeeping Supervisor indicated she was returning from break and saw Resident #7 rolling down the sidewalk from the apartment side of the building. The internal investigation lacked interviews from other staff members to indicate if they heard the alarm and why it was not responded to. During an interview on 2/08/12 at 3:10 p.m., the Regional Consultant indicated per interview with the Administrator at the time of the occurrence, the staff did not hear the alarm, they were in the dining room and the nurse was working the other side of the building. She indicated the staff did respond because they went out		OF CORRECTION OF CORRECTION 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/08/2012		
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Residential Residents heard the door alarm sound. The Housekeeping Supervisor indicated she was returning from break and saw Resident #7 rolling down the sidewalk from the apartment side of the building. The internal investigation lacked interviews from other staff members to indicate if they heard the alarm and why it was not responded to. During an interview on 2/08/12 at 3:10 p.m., the Regional Consultant indicated per interview with the Administrator at the time of the occurrence, the staff did not hear the alarm, they were in the dining room and the nurse was working the other side of the building. She indicated the staff did respond because they went out			10352 N 600 E COUNTY LINE RD				
alarm sound. The Housekeeping Supervisor indicated she was returning from break and saw Resident #7 rolling down the sidewalk from the apartment side of the building. The internal investigation lacked interviews from other staff members to indicate if they heard the alarm and why it was not responded to. During an interview on 2/08/12 at 3:10 p.m., the Regional Consultant indicated per interview with the Administrator at the time of the occurrence, the staff did not hear the alarm, they were in the dining room and the nurse was working the other side of the building. She indicated the staff did respond because they went out	PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
This deficiency was cited on 12/20/11. The facility failed to implement a systemic plan of correction to prevent recurrence. This F tag relates to Complaint: IN00100554. 3.1-45(a)(2)		alarm sound. The Housekeeping Supervisor indicated she was returning from break and saw Resident #7 rolling down the sidewalk from the apartment side of the building. The internal investigation lacked interviews from other staff members to indicate if they heard the alarm and why it was not responded to. During an interview on 2/08/12 at 3:10 p.m., the Regional Consultant indicated per interview with the Administrator at the time of the occurrence, the staff did not hear the alarm, they were in the dining room and the nurse was working the other side of the building. She indicated the staff did respond because they went out and got her. This deficiency was cited on 12/20/11. The facility failed to implement a systemic plan of correction to prevent recurrence. This F tag relates to Complaint: IN00100554.					

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